Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be additional reimbursement of $1,886.67 for date of service 03/27/01.

   b. The request was received on 04/02/02.

## II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/28/02
   b. HCFA 1450
   c. Audit of Medical Charges
   d. Example EOB(s) from other carriers
   e. Medical Records
   f. Provider's Initial Request for Medical Dispute dated 02/27/02

   Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/08/02
   b. Carrier's Response to the Provider's Initial Request for Medical Dispute dated 02/28/02
   c. Provider's complete Request for Medical Dispute Resolution
   d. Carrier Kemper Methodology
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The response from the insurance carrier was received in the Division on 04/08/02. Even though there is no carrier sign sheet in the Commission case file, the TWCC MDUL-1 form codes the carrier response as "Timely."

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

## III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 03/28/02 that, "We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES**, not professional fees. We feel that 19% paid on a revision of a scar and skin tag of the right little finger is not fair and reasonable. We feel that Kemper should reimburse us more appropriately as $451.57 does not cover our costs to perform this surgery…The surgery took about 30 minutes and the patient was here for a total of about 3 hours…. The burden of proof should be put back on the insurance carriers to prove that our charges are not fair and reasonable by what other ASC's are charging as they are the ones that get to see what others are charging for the same procedure/surgery….we have proven that other insurance carriers are and have been paying 85% - 100% of our billed charges….Our methodology is to bill according to the supplies, medications, equipment, operating room and recovery time that is used during a surgery and/or procedure….Enclosed are examples of bills for the same and similar type of treatment of other patients and their insurance companies interpretation of fair and reasonable…"

2. Respondent: The Respondent's representative states in the correspondence dated 04/08/02 that, "The Carrier's representative received the documentation for Medical Dispute Resolution provided by…on April 4, 2001 [sic] and this response is timely…. No Medical Fee Guideline…(MAR) applies to the services provided by the requestor as Facility Fees….The carrier has analyzed procedures done by Ambulatory Surgical Centers and grouped them in accordance with their intensity into eight groups or Groupers ranging from Level One, (lowest intensity) to Level Eight (highest intensity). This is based on where the CPT Code falls in the HCFA intensity grouper list. Fees have been assigned to each of the intensity levels and local economic conditions are taken into account when the reimbursement is calculated by using the HCFA wage index factor for that area…. The Respondent requests…a…finding that reimbursement of $451.57 for the Requestor's charges is fair and reasonable…"

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/27/01.

2. The provider billed $2,338.24 for disputed date of service, 03/27/01.

3. The carrier paid the provider $451.57 for date of service, 03/27/01.

4. The amount in dispute for the date of service is $1,886.67.

5. The carrier denied additional payment for date of service 03/27/01 by denial code, "705 M – NO MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area."

6. The services provided by the provider include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

7. The carrier denied the charges in dispute as "M – fair and reasonable." The carrier's response was timely, but no other EOB or medical audit was submitted, therefore, the Medical Review Division's decision is rendered based on denial codes submitted prior to this dispute being filed.

8. The carrier unbundled the treatment services for an ASC on the Audit for Medical Charges. According to Rule 133.1 (a) (E) (16), unbundling is "Submitting bills in a fragmented way, using separate billing codes for multiple treatments or services when there is a single billing code that includes all the treatments or services that were billed separately, or fragmenting one treatment or service into its component parts and coding each component part as if it were a separate treatment or service."

## V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Texas Labor Code Section 413.011 (d) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate."

Commission Rule 133.304 (i) (1-4) requires the carrier to explain how they arrived at what they consider a fair and reasonable reimbursement. The carrier submitted their methodology and though, the entire methodology may not necessarily be concurred with by the Medical Review Division, the requirements of the Rule has been met.

The provider submitted additional reimbursement data (EOBs from various carriers) in an attempt to demonstrate payments of fair and reasonable documentation for treatment of an injured individual of an equivalent standard of living in their geographical area. The provider's documentation failed to meet the criteria of 133.307 (g) (3) (D) of demonstrating, discussing, and justifying fair and reasonable reimbursement from other carriers for similar treatment.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine based on the parties submission of information, who has provided the more persuasive evidence. In this particular case, the carrier submitted a methodology, as required by 133.303 (i), which is sufficient to establish that the amount requested by the provider is not fair and reasonable. The health care provider has the burden to prove that the fees paid by the carrier were not fair and reasonable. The provider submitted EOB(s) from other carriers, but the documentation is insufficient to determine if the charge of the provider is fair and reasonable. The carrier failed to meet the criteria of 413.011 (d), therefore, no reimbursement is recommended.

The above Findings and Decision are hereby issued this 15th day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division